These Principles of Reimbursement are implemented in accordance with the appropriate provisions of the State's Administrative Procedures Act.

The State will pay to participating providers of long term care facility services who furnish services in accordance with the requirements of the Principles of Reimbursement the amount determined for services furnished by the provider under said Principles of Reimbursement.

If an overpayment to a participating provider of long term care services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount as provided for by Section 40-8.2-22 of the Rhode Island General Laws.

GENERAL

REPORTING

Reasonable Costs

The provision of Nursing Facility Care Services to Medicaid recipients is provided only to those individuals who are eligible for nursing facility services in accordance with Medicaid regulations relating to resources and income. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Department of Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. These Principles of Reimbursement, through application of rate ceilings, provide for payment of Nursing Facility Care services under the Medicaid Program on a prospective basis through rates that are reasonable and adequate to meet costs that must be incurred by efficiently and economically operated nursing facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those cost of an individual facility for items, goods and services which, when compared,

will not exceed the costs of like items, goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Where it is determined that reported costs exceed those levels and in the absence of proof that the situation was unavoidable, the excessive costs will be disallowed.

In the absence of specific definitions and/or elements of allowable and disallowable costs that may not be contained herein the Rules and Regulations of Federal Medicare - Title XVIII will prevail.

The State reserves the right to make determinations of allowable costs in areas not specifically covered in the Principles or in the Rules and Regulations of Federal Medicare - Title XVIII.

Upper Limits

In no case may payment exceed the facility's customary charges to the general public for such services.

Annual Cost Report BM-64

All facilities with the exception of Intermediate Care Facility - Public Institution for the Retarded must file an annual cost report BM-64 on a calendar year. The report format is determined by the State's Nursing Facility Rate Setting Unit and must be filed on or before March 31 following the close of the year. The Intermediate Care Facility - Public Institution for the Retarded will be allowed to file annual cost reports based upon a fiscal year basis in a format consistent with past reporting procedures.

Newly constructed facilities will be allowed a temporary rate subject to the submission to the Chief Long Term Care Reimbursement of a BM-64 cost report covering a six-month period from the beginning of operations. The rate will be determined in the manner described for all other facilities under these principles and subject to the same ceilings.

The report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit the BM-64 on time without written authorized extension from the Rate Setting Unit will be assigned a non-recoverable reduction of 20 percent of the previously assigned rate. Such rate reduction will continue on a month-to-month basis

until said BM-64 is submitted or facility is terminated from the program for failure to file BM-64 report within six months from the close of the reporting year.

A final BM-64 must be filed within 90 days after a change in ownership, closing of the facility or when the provider leaves the Medicaid program.

ADMISSION POLICY

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination in accordance with the provisions of Section 23-17.5-19 and 23-27.5-21 of the Rhode Island General Laws based solely upon specialized medical and related needs of the patient. In addition, as provided in Section 23-17.5-24 of the Rhode Island General Laws, patients shall have the right to remain in a facility after the depletion of private funds.

METHOD OF PAYMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED AND TO INTERMEDIATE CARE FACILITY PUBLIC INSTITUTION FOR THE RETARDED

The Principles of Reimbursement for Intermediate Care Facilities for the Mentally Retarded will be HIM-15, Federal Medicare, with the exclusion of the provision for a return

on net equity.

PERSONAL CLOTHING: ICF-MR

Rates of reimbursement assigned to Intermediate Care Facilities for the Mentally Retarded, exclusive of Ladd Center, will include an amount not to exceed one dollar ($1.00) per day per client for the cost of purchasing personal clothing. This one dollar ($1.00) per diem allowance for clothing is not to be commingled with the facility's operating funds, personal needs funds, resident earnings or any other funds. A separate account is to be maintained by the facility which will account for all client personal clothing revenue and expenditures. The client personal clothing account will be summarized on individual client ledger cards showing name, dates of deposits, withdrawals and balance. Each withdrawal is to be substantiated by an itemized paid bill identifying the client name, articles of clothing purchased, and the date of purchase.

The client ledger cards for personal clothing, when totalled, will agree to the balance of the established separate personal clothing account. This reconciliation must be done on at least a monthly basis.

The recognized personal clothing expenditure for each client will not exceed the amount of one dollar ($1.00) per day. The facility will be responsible in monitoring the expenditures to ensure that this limitation is not exceeded.

Therefore, the clothing fund account for a resident must not have a negative balance. Clothing funds are considered to be on the accrual basis of accounting.

When a client dies, is discharged to a non-ICF-MR facility (waiver, apartment program, etc.), is discharged to an ICF-MR which is not part of the same corporation, or is discharged to the community, it will be necessary for the facility to transmit to the Department of Human Services, Rate Setting Unit, any unexpended funds from that resident's Personal Clothing Account within a period of twenty days.

If a facility is decertified from the ICF-MR Program, or voluntarily withdraws from the Program, the entire amount from each residents personal clothing account must be remitted to the Department of Human Services, Rate Setting Unit within twenty days.

As of January 31 of each calendar year, it will be necessary for the facility to remit to the Department of Human Services any unexpended or unencumbered funds in individual clothing accounts in excess of $90.00 recorded as of midnight on December 31 of the previous year.

Audits by the Department of Administration - Bureau of Audits will be conducted on these accounts periodically in order to ensure compliance with the above specified requirements.

PARTICIPATION AND PAYMENTS

Facilities and at least 25% of all their nursing facility beds must be **dually certified** for participation in both the Federal Medicare - Title XVIII Program and the Rhode Island Medical Assistance - Medicaid Title XIX Program on and after October 1, 1990. Ideally all nursing facility beds should be dually certified.

METHOD FOR DETERMINING COST CENTER CEILINGS

BM-64 Cost Reports for calendar year 1991 for all certified and participating nursing facilities in continuous operation from January 1, 1991 through December 31, 1991, will be grouped into one level of care category and allowable cost per diems will be arrayed in descending order into the following seven cost center per diem groupings: a) Fixed Property Expenses, b) Other Property Related Expenses, c) Labor Related Expenses, d) Energy Expenses, e) All Other Expenses, f) OBRA-87 Expenses and g) Management Related Expenses. The appropriate percentiles as specified below will then be applied to this arrayed data and except for Other Property Related, will be increased by the annual percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services for rate years 1992 and 1993 and each subsequent July 1 beginning with the percentage adjustment recognized July 1, 1994, and in lieu of the application of the percentile adjustment to cost center ceilings for the rate year July 1, 1996 through June 30, 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) to cost center ceilings effective July 1, 1999.

a. **Fixed Property Expenses:**

This cost center grouping will include allowable costs reported in Accounts No. 451 - Real Estate Taxes, 451A - Personal Property Taxes and 451B - Fire District Tax. Costs will be allowed up to a ceiling maximum of the 100th percentile of the cost of all facilities arrayed.

b. **Other Property Related Expenses:**

This cost center grouping will include allowable costs reported in Accounts No. 452 - Interest, 453 - Rent/Lease, 453A - Lease of Equipment, 454 - Amortization of Leasehold Improvements, 455 - Building Depreciation, 455A - Building Improvements Depreciation, 457 -Equipment Depreciation and 466 - Motor Vehicle Depreciation. Costs will be allowed up to a ceiling maximum of $18.97 for facilities licensed, under construction, or that have made a significant financial commitment by July 1, 1993, or that have submitted certificate of need applications by June 1, 1993 and have received approval by September 30, 1993. For these facilities, the $18.97 ceiling maximum will apply to any future additions of bed capacity that do not exceed the lesser of ten beds or 10 percent of existing bed capacity. Also for these facilities, upon change of owner/operator the ceiling maximum will become $15.00. Costs for additions to bed capacity that exceed the 10 bed/10 percent limit and costs for newly constructed facilities will be allowed up to a ceiling maximum of the 70th percentile of the cost of all facilities

arrayed.

b. (1) Nursing Facility Bed Replacement-Effective September 1, 1996:

Definition of Bed Replacement is defined as licensed beds newly constructed as an alternative to renovating existing licensed beds and meet the eligibility requirements below:

i. a licensed nursing facility, certified to participate in the Rhode Island Medical Assistance Program and in continuous operation and under the same ownership for reimbursement purposes since July 1, 1967, and

ii. costs for renovating existing physical plant to modernize and to conform to fire safety code laws governing nursing facility construction make the costs of renovations fiscally unsound.

For those nursing facilities eligible to construct new nursing facility replacement beds the maximum allowable per diem cost in the Other Property Related Expenses cost center will be set at the rate of $18.97 subject to the following conditions:

a) replacement beds are licensed in a number no greater than the actual beds licensed in the existing facility, and constructed on one site, not multiple sites, and

b) if fewer replacement beds are constructed than are licensed in the existing facility the license for the difference in beds will be unconditionally surrendered to the Department of Health, and